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Original Communication

Lack of training in custodial medicine in the UK – A cause for concern?

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Abstract

This research demonstrates that forensic physicians in the United Kingdom (UK) who have not received academically approved introductory training in custodial medicine are failing to recognise adverse events in relation to patient safety and are missing forensic evidence. A model for future mandatory introductory training of forensic physicians is suggested.

Keywords: Forensic physician; Training; Clinical forensic medicine

Introduction

In the United Kingdom, the training of forensic physicians (also known as police surgeons and forensic medical examiners) has been very varied. For many years one of the most widely used training course was organised and delivered by National Police Training (Centrex) and because of the location, colloquially became the "Durham Course".

The Education and Research Committee of the former Association of Forensic Physicians (AFP) considered that it was important to try and standardise forensic physician (FP) training and defined an appropriate syllabus for an Introductory Training Course (ITC) in 2003. It subsequently commenced delivery of such a course in 2004. In addition, the AFP also had in place a system of accrediting training courses via its Training Advisory Group (TAG) in a similar way that courses for General Practitioners received Postgraduate Education Allowance (PGEA) approval.

Following the successful introduction of the newly designed course it became evident that the course was running in unnecessary competition with the Durham Course and following discussions with Centrex, the two courses were merged in 2005, to deliver a combined AFP/Centrex Introductory Training Course.

Following the creation of the Faculty of Forensic and Legal Medicine[1] in 2006, the AFP closed. In addition, Centrex has evolved into the National Policing Improvement Agency (NPIA) and the course is now run jointly by the Faculty and NPIA and meets NPIA quality approval standards which include an assessment. The course has been held at least four times per year with a maximum of 12 students on each course and in the past two years has trained approximately 100 forensic physicians. One of the features of the Faculty/NPIA course is that it includes numerous case scenarios and gives the student an opportunity to reflect on them. Such small group learning[2] allows the students to question and challenge assumptions and to develop a better understanding of a topic. Furthermore, using a student's previous experience[3] to look at custodial situations aids learning. All the resident tutors have, as a minimum, membership of the FFLM and extensive experience of the specialty.

In 1998, the Audit Commission[4] published its report on the provision of forensic medical services to the police and this led to several police forces beginning a process of outsourcing the service to commercial providers. By 2006, 42%

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of the 55 United Kingdom and Island Forces had been outsourced. Prior to this, apart from London where many FPs were full time, most FPs were part time, their main occupation being General Practitioners (GPs). With the advent of GP out of hours co-operatives in the 1990s and the new GP contract in 2004, many GPs stopped working as FPs and this led to a marked change in both the numbers and demographics of these doctors with a small number of commercial providers using doctors trained outside the United Kingdom working on a full time basis. In addition, some commercial providers and police forces employ paramedics and nurses to undertake some of this workload.

It became evident to the author, who was partly responsible for the delivery of the courses, from anecdotal comments made by students, that many felt they may have had adverse incidents in relation to patient safety and/or may have missed forensic evidence due to lack of training. Some doctors admitted that they had received no training and others had received limited training of questionable quality delivered by doctors who had limited experience of and no qualifications in clinical forensic medicine.

Method

The research aims were

- to identify the characteristics of doctors commencing work in clinical forensic medicine;
- to identify if doctors had completed an Introductory Training Course in Clinical Forensic Medicine and when this occurred in relation to the commencement of working;
- to identify if doctors had experienced an adverse incident in relation to patient safety through lack of training and
- to identify if doctors had experienced an adverse incident in relation to quality of forensic evidence through lack of training.

In 2005 a semi-structured postal questionnaire was sent to 806 members of the Association of Forensic Physicians in the United Kingdom (UK). The questionnaire was divided into three parts with part one asking five questions of a biographical nature, part two asking four questions relating to training and specifically if the doctor had completed an ITC and whether this was before commencing employment as a forensic physician and the third part asking, in relation to the practice of clinical forensic medicine whether

- they had experienced an adverse event in relation to patient safety;
- they had experienced quality issues in regard to forensic evidence;
- all new forensic physicians should complete an ITC and
- all new forensic physicians should complete an ITC before commencing forensic practice.

Data from the questionnaires were entered into an Access database on a personal computer.

Results

Of the 806 questionnaires, 449 replies were received, a 55% response rate. 74% were male and 26% female; 80% were actively working in general practice and 27% had a recognised qualification in clinical forensic medicine. Those doctors that were retired from the practice of clinical forensic medicine or who were engaged in exclusively sexual offence examiner work were excluded from the study leaving 357 doctors who formed the basis of the further analysis.

Of these remaining doctors, 254 (71%) had completed an ITC and of these, 92 (36%) had completed the course before commencing practice. 103 (29%) had not completed an ITC. Of those who had completed an ITC, 146 had attended a TAG approved course.

With respect to adverse incidents in relation to patient safety, 27 out of 357 had experienced an adverse incident; of these 25 had completed an ITC and 2 had not ($P > 0.001$). Adverse incidents were also reviewed by experience of doctors and it was noted that the greater the doctor's experience, the less likely a doctor was to have an adverse incident, though this was not statistically significant.

With respect to quality issues, 128 out of 357 had experienced an adverse event; of these 104 had completed an ITC and 24 had not ($P > 0.001$). The results also indicated that a doctor had a 40% chance of having experienced quality issues with this falling to 20% with more than 20 years experience ($P > 0.05$).

94% of doctors indicated a forensic physician should complete an ITC with nearly two thirds confirming that this should be before commencing forensic practice and many of the remainder commenting that it should be done early in their career.

Discussion

The study confirmed that the majority of doctors working as forensic physicians in the UK have a background in general practice.

Whilst numerous other authors[5–7] have commented on the limitations of training in clinical forensic medicine in the UK, there have been no studies that have produced evidence on the impact of lack of training in quantitative terms for quality issues or patient safety.

Following advice from the Education and Research Committee of the AFP, adverse incidents in relation to patient safety were deliberately not defined in the study but left entirely to the doctor to judge; similarly for quality issues in relation to forensic evidence. It is recognised that this could be considered a weakness in that this could result in a wide range of ideas on these matters. However,

it was considered that an individual doctor could make a reasoned decision in relation to what they would consider, with hindsight, might be an adverse incident or quality issue. Furthermore, the questionnaires were completely anonymous; so doctors had no fear of repercussions in answering frankly and honestly. These results indicate that doctors who have not completed an ITC do not think they have had adverse incidents in relation to patient safety and have not missed forensic evidence. But why is this? Either the untrained doctors are so good that they rarely have adverse events or as the author would suggest, the explanation is that they simply have no insight into what they are missing through lack of training. Put more simply "you don't know what you don't know".

It is of concern that nearly 30% of doctors had not undertaken an ITC. In what other branch of medicine would a doctor be allowed to work without appropriate training? The changing trend in the provision of clinical forensic medical services to private outsourced companies has previously been highlighted as a cause for concern. Norfolk[8] has commented that it is inappropriate for independent treatment centres to perform hip surgery with no specialist orthopaedic qualifications; in just the same way it is also inappropriate for police forces to employ or sub contract medical services and use doctors, who are required to assess and treat persons who are highly vulnerable and who often have multiple medical and psychological problems, without adequate training.

It is not known precisely what contractual arrangements all Forces have in relation to the training and commencement of work as forensic physicians or Health Care Professionals; however, it is known that my home force in Northamptonshire and the Metropolitan Police in particular, will not allow doctors to commence employment without first having completed a Faculty/NPIA ITC. These results would suggest that doctors would also support such a decision and is clearly in both the Forces and patients best interests that patient safety and forensic evidence is paramount.

The Faculty has been founded to achieve the following objectives:

- to promote for the public benefit the advancement of education and knowledge in the field of Forensic and Legal Medicine and
- to develop and maintain for the public benefit the good practice of Forensic and Legal Medicine by ensuring the highest professional standards of competence and ethical integrity.

The Faculty intends to exercise its powers[9] to establish a training pathway in Forensic and Legal Medicine and achieve specialist recognition of the specialty. It will also work with the General Medical Council to ensure that there are processes for the relicense and recertification of forensic physicians that are fit for purpose.

As an example of good practice, the longest established Sexual Offence Referral Centre (SARC) in the United Kingdom at St Mary's Hospital, Manchester has now developed an introductory course[10] for doctors wanting to work as sexual offence examiners which is accredited by the University of Manchester and which is endorsed by the FFLM. This type of model with courses accredited by a University and the FFLM should be extended to ITC's ensuring one of the first steps in establishing an appropriate training pathway in clinical forensic medicine.

As a proposal for good practice, it is suggested that:

- ACPO should consider advising its membership that the use of inappropriately trained doctors may increase their exposure to adverse incidents, loss of forensic evidence and concomitant increase in litigation.

And doctors contemplating working as a Forensic Physician should:

- Shadow an experienced Forensic Physician prior to commencing training (so that the type of work, patients and environment can be experienced first hand).
- Complete a University and Faculty accredited ITC.
- Undertake a period of practice supervised by an experienced forensic physician in accordance with the FFLM document[11] *A guide to practical induction training in clinical forensic medicine*.

In this way competence in clinical forensic will be achieved and adverse incidents in relation to patient safety and loss of forensic evidence will be minimised.

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